South West London
Clinical Commissioning Group

Policy Title: Serious Incident Management: Commissioned Services
Policy Number: SWLCCG/CL01

	Name	Role and Organisation	Date
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Authoriser	SMT	South West London Senior Management Team	31/03/2020

Approved By	Senior Management Team / Governing Body
Applies To	South West London CCG (The CCG), Governing Body Members, Committee Members and all staff working for, or on behalf of, NHS South West London and its CCGs.

Effective Date	01/04/2020
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Controlled Document

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Target Audience	Governing Body Members, Committee Members and all staff working for, or on behalf of, NHS South West London CCG.
Brief Description	This Policy sets out the principles by which we will manage incidents within contracted healthcare provider settings, including primary care, in South West London.
Action Required	Ensure that the contents of this Policy are shared with all Teams with in the South West London CCG, NHS Croydon and the associated Health and Care Partnership. The Chief of Staff South West London will establish and maintain a corporate register of all policies and their status and will ensure that these are appropriately reflected on the website. All members of CCG staff will ensure they are aware of their responsibilities in relation to the Policy and adhere to the requirements of the Policy as it relates to their role.

Contents

1. Introduction

1.1 Introduction

1.1.1 NHS South West London Clinical Commissioning Group (CCG), working in collaboration with healthcare providers, want to ensure that patients have safe and effective treatment and care. As a CCG, we want to approach patient safety proactively, identifying risks through systems thinking and an understanding of human factors.

The CCG will support healthcare providers to enable all staff to recognise risk, report incidents and investigate them appropriately. This will support patients, their families and carers to have a positive experience of healthcare, even when something goes wrong.

NHS England and Improvement published the Patient Safety Strategy in July 2019 its key principles are:

- **Insight**: improving understanding of safety by drawing intelligence from multiple sources of patient safety information
- **Involvement:** equipping patients, staff and partners with the skills and opportunities to improve patient safety throughout the whole system
- **Improvement:** designing and supporting programmes that deliver effective and sustainable change in the most important areas

The goal of the CCG is to support the development of our providers to have an organisation wide safety culture incorporating the principles of the Patient Safety Strategy

While it is recognised that we are moving towards a new system and process, we are required to work within the 2015/16 framework until the implementation of the new framework and recording system.

1.1.2 To provide overview and assurance on the processes and related to the management of serious incidents, including never events and homicide inquires.
To support best practice and meet statutory and mandatory requirements in serious incident management.
For incidents to be scrutinised, approved for closure and the processes monitored by the appropriate designated Group or Committee.

1.2 Policy Statement

The purpose of this policy is to set out the principles for the management of incidents within contracted services in South West London**.**

1.3 Legal, Statutory, Mandatory, and Best Practice Requirements

There is a statutory requirement for all healthcare providers to report incidents that meet the criteria set out in the Serious incident framework (2016) on the current reporting systems and undertake an investigation of the incident.

The NHS standard contract sets out National Quality Requirements and Operational Standards, these are generally monitored through contract meetings, performance against these standards may impact on organisations management of incident management.

NHS England and NHS Improvement have developed a new approach and recording mechanism for incident management which is currently being piloted, this will be incorporated into the policy as it is published.

1.4 Scope

This Policy applies to all staff who work within or support the management of incidents within NHS South West London CCG.

This policy covers all staff that support the management of incidents or have direct responsibility for ensuring the safe and effective care of users, families, friends or the public in services commissioned by NHS South West London CCG.

This Policy applies to all individuals working for, or on behalf of the above organisation(s), including those employed on permanent or fixed term contracts, interims, self-employed contractors, Governing Body Members, Clinical Leads, Locality Leads, and volunteers.

2. Definitions

Serious incident: are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant that they warrant a comprehensive response.

Never Event are serious incidents that are entirely preventable because guidance or safety recommendations providing strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers

Incidents and Near Misses are events where the collective learning could impact on preventing future harm through systems change or understanding of human factor influence on outcomes.

Themes: where information from multiple sources e.g. incidents, patient experience, complaints/PALS, Friends and family tests, performance data, staff surveys, provides knowledge to support learning to improve care and treatment.

Thematic review: focuses on examining themes or patterns within data. It goes beyond simply counting occurrences of documented or oral communication regarding a topic and explores explicit and implicit meanings.

Strategic Executive Investigation System (StEIS): NHSE & I system for recording incidents as set out in the Serous Incident Reporting Framework

Forward notification: Appropriate parties will be notified of the incident under investigation, this will be determined after assessment of the notification as other processes may need to be enacted, for instance Safeguarding, Medicines Management.

Upward Notification: where the incident may cause media interest, impact on organisational reputation or is so significant that immediate action and support is required, an escalation process will be undertaken which may involve Directors, Managing Directors, Chief Nurse, Responsible Officer and NHS England.

Root Cause Analysis (RCA): a process to investigate incidents. The final reports are sometimes referred to as RCA.

De-escalation: where on investigation the provider finds that the incident does not meet serious incident criteria and requests that the incident is removed from StEIS. The provider may then go on to undertake an internal investigation

Clock Stop: where the count down for the investigation time frame is stopped, this must meet the criteria set out in the framework, this is usually related to a police investigation.

Further Information Requests (FIRs): the CCG requests further information to clarify points within the investigation report

SI Management System: the internal CCG incident management system which supports timely actions within the process and reporting for CCG assurance

Serious Incident Review Groups or Serious Incident Groups (SIRG/SIG) Multi-disciplinary groups with representation from providers safety teams, clinicians and safeguarding, CCG, NHSE (as appropriate) and lay members (invited) to review reports, monitor action plans and draw out themes for in-depth review, to challenge and support providers.

Primary care significant events is any unintended or unexpected event, which could or did lead to harm of one or more patients. This includes incidents which did not cause harm but could have done, or where the event should have been prevented.

Appendix 4: details aligned investigation processes

3. Responsibilities:

3.1 The Governing Body

The CCG has responsibility to the Governing Body for setting the strategic context in which serious incident and incident management process documents are developed, and for establishing a scheme of governance for the formal review and approval of serious incidents.

3.2 Senior Responsible Officer

The South West London Clinical Commissioning Group Accountable Officer is accountable for this Policy, and for supporting the implementation thereof, including ensuring that the Policy complies with all legal, statutory, mandatory, and best practice guidance requirements**.**

3.3 Chief Nurse and Executive Director for Quality

The CCG Chief Nurse and Executive Director of Quality will ensure SWL CCG has effective staffing, systems, processes and structures in place, to support the management of serious incidents, including never events.

The Chief Nurse and Executive Director of Quality is responsible for ensuring that:

- This policy is drafted, approved and disseminated;
- There is an appropriate system to record and monitor incidents across South West London;
- Mechanisms are in place for the regular evaluation of the implementation and effectiveness of the policy;
- The Accountable Officer and governing body members are made aware of any concerns relating to a contracted service; and
- The CCG has in place assurance processes to ensure compliance with the serious incident policy and contract monitoring of providers, which includes the support of training and learning events for providers and CCG incident management team.

3.4 Director of Quality

The Director of Quality Kingston, Richmond (and Croydon) is designated executive Lead for patient safety and is responsible for ensuring processes for incident management are in line with national frameworks and that learning from incidents supports commissioning. They are responsible for ensuring that learning is shared within the CCG.

The Director of Quality, Kingston, Richmond (and Croydon) is the Executive Lead for safeguarding adults and children and young persons. Serious Case Reviews for both children and adults will inform incident investigations and vice versa.

3.5 Lead Quality Manager

The Lead Quality manager has the responsibility of monitoring all incidents uploaded onto the national incident reporting system (currently STEIS) by commissioned providers for South West London CCG.

For liaising with providers and offering support, clinical expertise (or seeking appropriate clinical expertise) and guidance, ensuring that incidents are investigated effectively, actions are appropriate and completed. Ensuring themes are drawn out and quality improvement is embedded in the incident management process.

To ensure that substantial and robust internal systems are in place to provide assurance to borough and place committees, the CCG Quality & Performance Committee and the Governing Body.

3.6 Quality Manager

The Quality Manager will support the monitoring of all incidents uploaded onto the national incident reporting system (currently STEIS) by commissioned providers for South West London CCG.

Will liaise with providers, offering support, clinical expertise and guidance for the effective management of incidents including that appropriate actions are completed. Recognise and

support the drawing out of themes and that quality improvement is embedded in the incident management process.

To support the Lead Quality Manager(s) in ensuring robust internal systems are in place to provide assurance to borough and place committees, the CCG Quality & Performance Committee and the Governing Body.

3.7 Quality Support Officer(s)

The quality support officer will work with the clinical quality manager/lead to ensure there is accurate and timely review of serious incidents, maintain an accurate record of the reviews undertaken and the outcomes.

Liaise with the provider to ensure that the reports are received in a timely manner, review and update STEIS. Supporting the assurance process by supporting and undertaking reports as required.

3.8 Contracted Providers (NHS Trusts, community health trust etc)

It is the provider's responsibility to ensure they have systems in place and a culture that supports, adequate and timely reporting of incidents, including near misses, to the national system and where appropriate escalates to commissioners and NHS England.

To ensure that incidents are reviewed to ascertain the level of investigation required and appropriate and timely investigation of incident are undertaken.

To ensure and enable the sharing of learning across the organisation from incident investigations and thematic reviews.

3.9 General Practitioner Governance Leads

This role is currently being negotiated and developed with the Primary Care Development team: this section will be updated when agreed,

4. Incident Management Process

4.1 Please see appendices 2, 2.1 & 3: flow charts on serious incident processes and reporting structures

4.2 Please see appendix 4: table of connections to other investigation processes

5. Review

This policy should be reviewed after 1 year and/or as the implementation of the Patient Safety Incident Response Framework (PSIRF) and Patient Safety Incident Management System (PSIMS) are implemented, as new developments occur and at least 3 yearly.

6. Templates/Forms

There are no specific templates or forms used by the CCG for the implementation of this policy. Reporting is by central national system and the recording of this will be undertaken on a CCG wide data system which is accessible to those staff who require it. Root Cause Analysis or incident investigation templates are decided by provider organisations.

7. Internal and External References

Please also see appendix 4 a table of aligned incident management processes

7.1 Internal References

- Safeguarding Adults policy
- Safeguarding Children's policy
- Serious Incident Policies from historical CCGs: Kingston, Merton, Richmond, Sutton and Wandsworth
- MCA and DoLS policy
- Risk Management Policy / Board Assurance Framework

7.2 External References

- NHS England policies & guidance for the management of incidents (multiple
- Child Death Review: Statutory and Operational Guidance (England)
- NHS England policies and guidance on Safeguarding Adults and Children
- NICE Guidance and Royal Colleges Academic papers on learning from incidents (various)
- Health and Safety Executive (2018) Incident Management Framework
- Health Service Executive: Approaches to Incident Review
- Organisational Accident Causation Model: Taylor-Adams 2001
- "What-You-Look-For-Is-What-You-Find" Lundberg, Rollenhagen, Hollnagel, 2009.
- STAMP Shappell, 2012.
- NHS Standard contract

8. Monitoring

There will be monthly reporting to the Borough meetings and Place quality meetings and quarterly reporting to the overarching South West London Quality and Performance Oversight Committee. There will be a yearly report with thematic analysis to support commissioning intentions and collaborative working.

Where incidents meet criteria as set out in the serious incident reporting framework (2016) contracted providers are required to report to NHS England. For instance, homicides where the perpetrator was in receipt of mental healthcare or when a never event occurs. The CCG will liaise with NHSE to support the investigation process and to ensure that the provider is achieving the actions required. When requested or required the CCG will provide a report to NHSE.

If you have any suggestions for the improvement of this Policy, please contact the author Ruth Harkness ruth.harkness@swlondon.nhs.uk with your suggestions, for consideration.

9. Equality Impact Assessment

An Equality Impact Assessment has been completed for this Policy (Appendix 1), and no negative impact upon persons with protected characteristics has been identified.

10. Change History

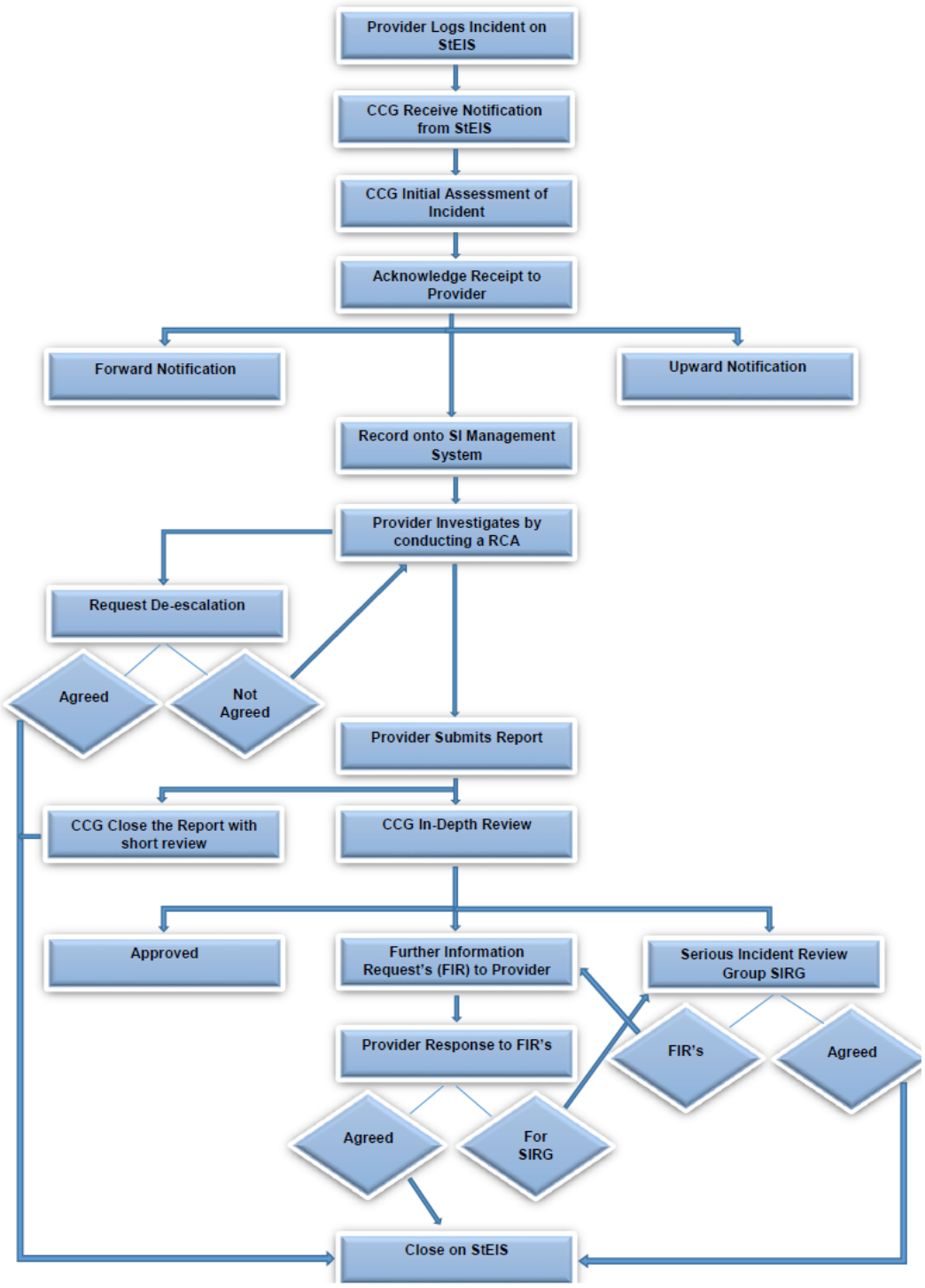
Policy Number	Effective Date	Significant Changes
	01/04/2020	

11. Appendix 1 - Equality Impact Assessment

	Mandatory Questions	Yes/No/NA	Comments
1.	Does the Policy affect any group less or more favourably than another on the basis of:		
	Age?	No	
	Disability?	No	
	Gender?	No	
	Gender identity?	No	
	Marriage or civil partnership?	No	
	Pregnancy and maternity or paternity?	No	
	Race?	No	
	Religion or belief?	No	
	Sexual orientation?	No	
2.	Is there any evidence that any groups are affected differently by the Policy and if so, what is the evidence?	No	
3.	Is any impact of the Policy likely to be negative?	No	
4.	If any impact of the Policy is likely to be negative, can the impact be avoided and if so, how?	NA	
5.	If a negative impact can't be avoided, what, if any, are the reasons the Policy should continue in its current form?	NA	
6.	Where relevant, does the Policy support the FREDA principles: Fairness, Respect, Equality, Dignity and Autonomy?	Yes	

If you have identified a potential discriminatory impact of this Policy, please contact the Chief of Staff.

12. Appendix 2 - Serious Incident Management Process



13. Appendix 2.1 Description of Process Boxes

Initial Assessment of Incident: The CCG will flag specific incidents for in-depth review. This will include Never-Events, themed incidents at the same provider, themed incidents across providers, Homicides (as a NHSE framework requirement), incidents that providers wish us to review in depth and a random selection from all providers. To identify themes will require knowledge of and good relationships with providers.

Forward notification: Appropriate parties will be notified of the incident under investigation, this will be determined after assessment of the notification as other processes may need to be enacted, for instance Safeguarding, Medicines Management

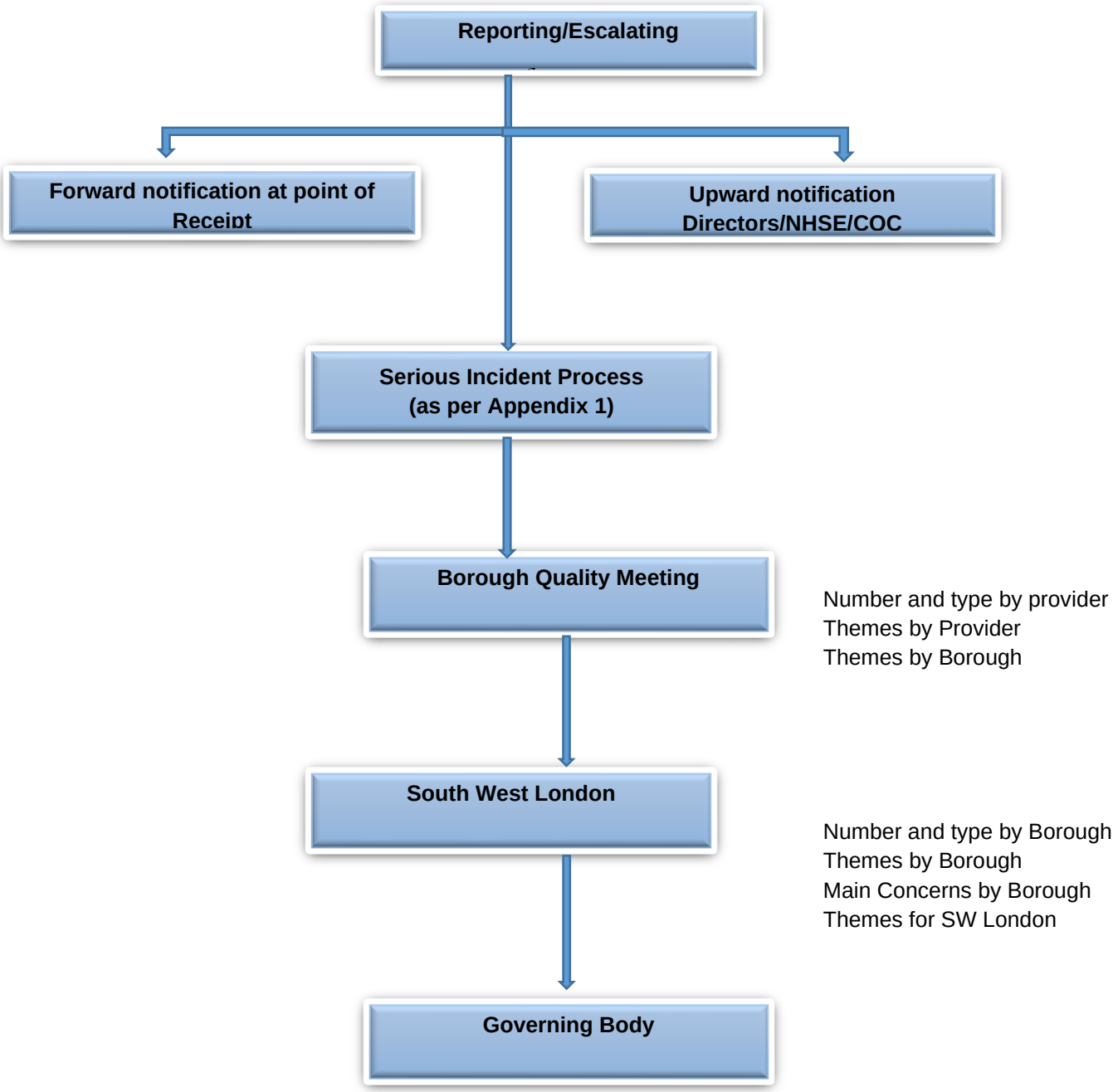
Upward Notification: where the incident could cause media interest, impact on organisational reputation or is so significant that immediate action and support is required an escalation process will be undertaken which may involve Directors, Managing Directors, Chief Nurse, Responsible Officer and NHS England.

Record onto the SI Management System: this is the internal CCG incident management system which supports timely actions within the process and reporting for CCG assurance

CCG Close the Report with Short Review: These reports would be reviewed to ensure that basic components are present; recommendations, root cause, action plan. They will be reports that have not been selected as per the criteria set out earlier and will be reliant on good relationships with the providers.

CCG In-Depth Review; this will include all reports as set out in Initial assessment and may form part of the serious incident review group. If while undertaking reviews there are concerns regarding any part of the investigation or the content or style of the report, further challenge and support will be given, and further sampling may be undertaken.
Quality Improvement methodology/ Training and expert knowledge may be considered.

14. Appendix 3 - Serious Incident Reporting Structure



15. Appendix 4 – Investigation Process

Investigation Processes aligned with the Serious Incident policy	
Healthcare Safety Investigation Branch (HSIB) (currently undertake investigation of all Maternity related deaths)	Conduct independent investigations of patient safety concerns in NHS-funded care across England. The safety recommendations aim to improve healthcare systems and processes in order to reduce risk and improve safety. HSIB is funded by the Department of Health & Social Care and hosted by NHS England and NHS Improvement. It hopes to become an independent body using the model of the Air Accident Investigation Branch
Child Death Overview Panel (CDOP)	This process is a statutory requirement for all organisations It is the mandatory reporting system for all children who die over 24 weeks' gestation. It is a Multi-agency strategic meeting consisting of representation from police, CCG, healthcare providers and children's social care to elicit the learning and themes across the STP. Child Death Review Meeting: The child death review meeting is the operational meeting investigating why and how the child died this is a local meeting that feeds into CDOP. The root cause analysis report from the provider will be used within this process.
Learning Disability Mortality Review (LeDER)	The Learning Disability Mortality Review Programme was established to drive improvement in the quality of health and social care service delivery for people with learning disabilities (LD) by looking at why people with learning disabilities typically die much earlier than average
Homicide Review (this includes mental health and domestic)	After the provider investigates and provides a report, NHSE will review it and decide whether an independent review is required. This independent review may provide more actions for the provider, which will be reviewed at regular intervals with the lead CCG and NHSE to ensure the provider is achieving the actions required.
Police Investigations	Police investigations may stop the provider investigation process as to continue could interfere with the criminal investigation.
Coroners Inquests	An inquest is an investigation into a death which appears to be due to unknown, violent or unnatural causes. The purpose is to find out who the deceased was and where, when and how they died. A coroner is obliged to investigate deaths which are not obviously "natural".